A, hepatitis B, hepatitis C, human immunodeficiency virus, brucellosis, coxsackievirus, echovirus, syphilis, and mycoplasma were negative. The titer of antibodies to *Ehrlichia canis* (Mayo Medical Laboratories, Rochester, MN) rose from <1:16 (day 4 of his illness) to 1:256 (day 21).

We have described a patient with acute ehrlichiosis who had symptomatic heart failure and left ventricular dilatation without electrocardiographic or chemical evidence of myocarditis. Human ehrlichiosis is now thought to be due to *Ehrlichia chaffeensis* [1]. Disease severity varies greatly, but typical findings include malaise, fever, myalgias, headache, leukopenia, thrombocytopenia, and elevated transaminase levels [2–5].

The frequency and severity of cardiac involvement associated with ehrlichiosis are not clear. Two reports from the Centers for Disease Control and Prevention for the years 1985–1990 noted cardiomegaly in up to 16% of patients [2, 5]. However, these articles did not report whether symptomatic heart failure developed in these patients, and evidence of myocarditis was not reported. Many of the patients in these articles were older than age 65 years, and cardiomegaly may have been a reflection of an underlying disease unrelated to ehrlichiosis. A literature search revealed one report of clearly documented cardiac involvement in a 43-year-old man in whom transient cardiac failure and left ventricular dilatation associated with myocarditis developed [6]. In both that patient and our patient, heart failure and left ventricular dilatation were clearly related to the acute infection. The patients were young and had no history of heart disease, and both progression and regression of the cardiac dilatation were observed.

The two patients differ with respect to evidence of myocarditis: in the previous case [6], electrocardiographic and chemical evidence of myocarditis was found. There were no such findings in our case. Myocarditis produces varied clinical manifestations, and the dissociation between cardiac dysfunction and evidence of myocarditis seen in our patient suggests that acute ehrlichia infection can produce cardiac dysfunction with little myocardial inflammation. While the etiology of cardiac involvement in ehrlichiosis is not known, it has been noted that human and canine cases of ehrlichiosis are remarkably similar and that infected dogs have multifocal perivascular mononuclear infiltrates in the kidneys, brain, spinal cord, and heart [3].

In conclusion, cardiac dilatation and symptomatic heart failure are part of the spectrum of human ehrlichiosis. In our patient, this process was not associated with electrocardiographic or chemical evidence of myocarditis and was self-limited.

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**Penicillin-Resistant *Aerococcus viridans* Bacteremia in a Child Receiving Prophylaxis for Sickle-Cell Disease**

We report a case of *Aerococcus viridans* bacteremia in a child who was receiving prophylactic penicillin for sickle-cell disease (SCD); to our knowledge, this is only the second reported case of infection due to a penicillin-resistant strain.

An 11-month-old black female with SCD presented to the emergency department with a rectal temperature of 103°F. She was receiving prophylactic penicillin (125 mg) twice daily. Findings on physical examination were normal. The WBC count was 6,300/mm³ with 59% neutrophils, 9% band forms, and 20% lymphocytes. Results of a urinalysis were negative. Urine and blood for cultures were obtained; she received a single dose of im ceftriaxone (50 mg/kg) and was discharged.

The following day, the patient returned to the clinic; she appeared well but had a temperature to 100.7°F. She again received im ceftriaxone (50 mg/kg) and was sent home. Later that day, cultures of the blood obtained 29 hours earlier yielded gram-positive cocci in clusters. She was recalled for admission to the hospital, and the results of physical examination were unchanged, as were the laboratory values. Culture of blood was repeated, and the patient was treated with iv cefuroxime.

The organism was identified as β-lactamase-negative *A. viridans*. Susceptibility testing by the Kirby-Bauer disk method revealed that it was resistant to penicillin (zone of inhibition, 28 mm; that for a susceptible nonpneumococcal streptococcus, >29 mm). It was susceptible to cephalosporins, vancomycin, clindamycin, gentamicin, amoxicillin/clavulanic acid, and tetracycline. The MIC of penicillin for the organism (0.5 μg/mL) indicated intermediate resistance (the standard MIC for nonpneumococcal streptococci is ≤0.12 μg/mL). The patient became afibrile and was discharged with a prescription for po cephalexin (50 mg/ [kg·d] q8h), to complete a 10-day course of antibiotic therapy (including cefuroxime). Repeated blood cultures were negative. *A. viridans*, which was first described in 1953, is similar to α-hemolytic streptococci and enterococci but forms tetrad in broth media. Sources of the organism include clothing, fomites, skin, dust, and the upper respiratory tract [1, 2]. It is often considered...
Septic Prepatellar Bursitis Caused by Stenotrophomonas (Xanthomonas) maltophilia

Stenotrophomonas maltophilia, a multidrug-resistant gram-negative bacillus [1], is increasingly recognized as an important nosocomial pathogen [2, 3]. We describe an unusual case of bursitis caused by S. maltophilia that we believe is the first such case in the literature.

A 72-year-old man presented with swelling, erythema, and pain of 14 days’ duration in the left knee. He did not have any history of alcoholism, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and adenocarcinoma of the stomach treated by subtotal gastrectomy. At the time of admission, the patient had been taking amoxicillin/clavulanic acid for 7 days for a presumed urinary tract infection.

On physical examination, the patient was afebrile. There was warmth, erythema, swelling, and tenderness in the left prepatellar region. There was no tenderness along the lateral and medial aspects of the left knee joint, but moderate decrease in range of motion was observed secondary to pain. No other joints or bursae were inflamed. The patient’s leukocyte count was 17,900/mm³, with 77% neutrophils. A gram stain of aspirate obtained from the bursa showed numerous WBCs and gram-negative bacilli. Culture of the bursal fluid yielded S. maltophilia that was susceptible to trimethoprim-sulfamethoxazole, ticarcillin/clavulanic acid, and ciprofloxacin. Blood and urine cultures were sterile. Results of a radiological examination of both of the patient’s knees were unremarkable. The patient was treated with ciprofloxacin (750 mg orally twice per day for 2 weeks) as an outpatient. The infection promptly resolved without the need for repeated aspirations of the prepatellar bursa.

Septic bursitis almost exclusively involves the prepatellar and olecranon bursae [4–10]. Staphylococcus aureus is the pathogen most commonly encountered in these infections, followed by streptococci and coagulase-negative staphylococci [4–6, 9]. A total of only nine episodes of gram-negative septic bursitis in eight patients

References